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Women's Migration, Urban Poverty and Child Health in Rajasthan

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1. Introduction

The paper is concerned with the high levels of infant and child illness and death amongst poor urban slum communities in Rajasthan, a state with one of the highest infant mortality rates in India. Urban poverty is significant in Rajasthan with a fifth of the urban population living below the poverty line and in slums (UHRC 2006). Increasing numbers of poor migrants in search of employment contribute to the rising levels of urban poverty in cities such as Jaipur, where the present study is based.

The research presented in this paper specifically focuses on the positive and negative roles of migration for the survival prospects of children in Rajasthan. While migration is an increasing feature which defines the lives of the rural and urban poor in India, few studies have considered its effects on the health of migrants and their families.

A key point we make in the paper is that many poor people are forced to move on a regular and chronic basis and that this movement has both negative and positive consequences for their health and nutritional status.

The paper examines the consequences of internal migration for women's reproductive experiences and for their children's health and is based on work between 2002-2004 carried out by Unnithan-Kumar in two urban slums (*basti*) in Jaipur city, the capital of Rajasthan in NW India (wherever 'I' is used in the paper it refers specifically to her experience and interpretation). It draws on collaborative quantitative work with McNay and Castaldo, where we focus on the migration experiences of approximately 100 women from their birth (rather than on their last move, as is common in migration literature), their experiences of giving birth and the loss of their children. It also draws on Unnithan-Kumar's long term knowledge of the field, including an ethnographic study where she found ambivalence in the effects of migration on poor rural women's reproductive choices in Jaipur: enhanced access to health services in the city both expanded possibilities for reproductive autonomy but also placed women under new types of biomedical control (Unnithan-Kumar 2004).

In the context of poverty-related migration in Rajasthan, health was not the primary factor or even a secondary consideration underlying migration. Rather, migration was undertaken, or indeed forced upon individuals and families as a means to gain employment, income and related economic well-being and security. Health and physical well-being were regarded as a consequence of economic well-being (also noted by Sinha 2005), rather than contributing to it. The connection between health and migration then

emerges as an indirect consequence of migration rather than being directly related to it. The health consequences of migration result from the changing social relationships, economic conditions and related health-seeking behaviour, as discussed below. In Rajasthan, the contradiction which migrants faced between an increased availability of health services, and their inability to access these services, was particularly reflected in the ambivalent ways in which migrants viewed their moves to the city. Migrants living in poor urban slums suffer from the lack of basic public provisions such as sanitation and water such that health is not the only service they miss out on. Moreover, it is not enough that migration brings migrants to a place where there are more health services available; the question is whether their changed social and economic conditions enable them to take advantage of such services. Mobility in the context of such insecurity presents a particular challenge for the poor and for policy makers.

Migration itself has to be understood in the distinctive context of Rajasthan, a dominantly poor agrarian economy, where strict social rules define women's marital and reproductive roles and relationships, great social pressure for producing children, and a high infant and maternal mortality rate. In gender terms, women experience migration differently from men and almost universally at the time of their marriage. Migrant women in Rajasthan often move greater distances at marriage or shortly thereafter than non-migrant women. The economic roles of migrant women change and so does their relationship with members of their immediate and extended families. The relationships with women, outside those defined by kinship, expand, and combined with a change in their access to health-services, alters the social and medical setting in which migrant women experience birthing and motherhood. This has further implications for the quality of life that their children will experience. The shifts in mothers' work and nutrition and the environmental conditions in the *basti* (slum) in which they live, are perhaps the two most important migration-related factors to have a profound impact on the health and survival of their infants and children. Overall, there seems to be a greater tendency for the more recently migrated women to experience increased child mortality and make poorer use of preventive health services than longer term residents. These findings complement the works of Brockerhoff (1994) and Stephenson et al (2003) which suggest that the rates of child mortality experienced by rural migrants lies between that of rural and urban non-migrants. In the work presented here we suggest some reasons why this may be the case (unlike the demographic studies mentioned which highlight the pattern but not the reasons for the increase noted), as well as describe other occasions where straightforward patterns are more difficult to discern.

The high rate of child mortality among poor families in rural and urban areas in Rajasthan is a well known, and a well documented demographic fact. Rajasthan is among the states in India which has the

highest rates of infant mortality at 80 deaths per 1000 live births and an under 5 mortality rate of 114.9 (NFHS-2, 1998/99, UHRC 2006). The infant mortality rate among the urban poor in Rajasthan is 98.2 deaths per 1000 live births with an under 5 mortality rate at 162.3 which are significantly higher than the average for the state (UHRC 2006). At an all-India level, the infant and child mortality rates are currently estimated to be at the level of 72 deaths and 105 deaths per 1000 live births respectively, and considered to be stabilising after a rate of decline noted in the 1990s (Misra, Chatterjee, Rao, 2004). There is, however, significant regional variation within and between the Indian states with regard to these figures. Kerala has an IMR of 14 which is comparable to developed countries, while Rajasthan's figure of 80 brings it close to the high infant mortality experienced in some of the worst affected parts of the world such as in sub-Saharan Africa (Misra, Chatterjee, Rao, 2004).

Infant deaths have been further analysed in the NFHS-2 Rajasthan report according to place of residence (rural/urban), religion, socio-economic factors, the age of the mother, birth interval and the sex of the child. Migration is not a specified category of analysis and in this sense the material provided in this chapter builds upon and is additional to that provided in the NFHS reports. The latest report notes that there is a significant rural-urban differential in the mortality figures, with neonatal, post-neonatal and child mortality figures for rural areas all being higher by 12%, 33% and 69% respectively, compared to the urban figures (NFHS-2, 2001, 119). With the exception of child mortality figures, all mortality rates are higher (by 22%) for Hindus than for Muslims (ibid, 121). All mortality figures are high for children born with a birth interval of less than 24 months and for children of very young and older mothers (taken to be at the ages of 15 years and 49 years respectively). Of further relevance to this paper is the observation of the report that children in households of low standards of living have twice as high rates of infant and child mortality than children living in households of higher economic standards (ibid. p.122). In general, child mortality is found to be inversely related to socio-economic status (for example, Dasgupta, 1997). Socio-economic factors may thus negate the effects of migration. Stephenson, Mathews and Macdonald (2003), for example, found this to be the case in their statistical survey of the NFHS (1991/1992) data on the impact of rural-urban migration for under 2 child mortality in India.

The NFHS-2 figures and studies based on it are a useful guide to understanding the scale of mortality and poverty-related trends which define the region of Rajasthan, the focus of this chapter. However, the NFHS reports are too general, as they lack district-level information (Bose, 2006), and along with similar statistical tabulations are often insufficient in explaining the reasons underlying the figures that are presented or the direction of causality. So, for example, while short birth intervals are connected to

higher child loss, it is not clear whether they act as cause or effect. In fact, as Dasgupta (1997) shows for rural Punjab, and the material in this chapter also suggests, short birth intervals are caused by child loss rather than a reason for their occurrence. This is because, 'those who have lost children are pushed into more stressful reproductive cycles of shorter birth intervals and higher fertility' (1997:201).

The NFHS studies are also unable to convey a sense of scale regarding the morbidities (illness which has the potential of resulting in death) affecting the wider population, or how such morbidities are perceived, experienced, negotiated and shift with migration. The work presented in the following sections is an attempt to redress these gaps by focusing on migrant perceptions, and is based on detailed personal accounts of residents of a *basti* (slum) in Jaipur city, the capital of Rajasthan. Child health is approached in terms of women's experiences of migration and its impact on the birthing and nurturing of their children. To my knowledge this perspective has not been undertaken before. The advantages of an emic-based, interpretive, anthropological approach, focussing on differently positioned women's perceptions of migration, are that it enables a nuanced understanding of the diverse meanings associated with mobility and with health as embodied and lived experiences.

2. Paradoxes of Life in KN Basti: implications for health

The complexities involved in searching for a clear-cut definition of mobility, and in determining the relation between migration and health in Rajasthan are addressed in this section mainly through the accounts of a group of women living in KN *basti* (a pseudonym) as recounted to my research assistant and myself in August 2004. Apart from the women's accounts of child mortality and illness, the issue of children's health is further broached through the accounts of some of the older Hindu and Muslim children I met. These are children who have survived the risks of infant mortality (the 0-5year period) and whose health is seldom the subject of sustained research.

2.1 The context of KN basti

KN *basti* is among the smaller slums in Jaipur, a city which has several large established *basti* with over 500 households each. (There are no existing reliable data on the number of *basti* or the population in these settlements.) Overall there are approximately 2.32 million people (2001 census statistics) in Jaipur, which has experienced a 59 per cent increase in its population in the period from 1991-2001 and an extension of the city limits of somewhere between 10-20 sq. km into the surrounding peri-urban area. The KN *basti*, according to oral accounts of its residents, originated in the form of a grant of land given

by the ruling princes to a family of *Madari* (Muslim community of performers) for their services as courtly performers, mainly as puppeteers. The exact dates of this transfer remain hazy but the area has been occupied by these families since the time of city planning in Jaipur (1950s) and following Indian independence in 1947. It has undergone intensification during the 1970s and 1980s when it underwent significant expansion and families of Harijans (untouchable Hindu castes) began to settle in the area.

More recently, over the past 5 years or so, following disputes between the state government and the Jaipur royal family, portions of the land occupied by the *basti* have been seized by the municipal authorities and the people have been resettled on the outskirts of the city. As a result of this forcible resettlement, the basti is said to have declined in its population from 3,000 to 1,500 people and now has approximately 300 households. At each change of local government, a survey is conducted to verify plots and house numbers. There has been a rumour at least since the past two years that the whole basti will be 'lifted' and residents will be given plots of land elsewhere. *Basti* residents who own their plots are keen to remain as owners in order to claim rights to the resettled plot. Nevertheless, according to local residents and our own observations, people are still coming in to live in the *basti,* and this is made possible through the renting of rooms.

The general conditions for most households in KN *basti* are not good. Nearly 77 of the 100 households in our survey did not have running water or a toilet facility and used water from the public piped water tap. The nearby *nallah* (open drain) and open field at the back of the *basti* were used for defecation. Younger children defecate near the doorstep or in front of the *basti* on the road and this is then thrown into the drain. Most households had an open sewer and sewage collected in a hole dug in front of the house. I was told that this was emptied into the *nallah* when it got full. Most residents lived in a one-room dwelling. The main source of fuel was firewood (53%), followed by gas and kerosene. Almost 60% of households owned a bicycle, scooter or motorbike, 73% possessed or rented a TV, radio or fridge with nearly 91% having access to a fan or cooler. In terms of their occupations, *basti* residents worked as wage labourers (mostly men), domestic workers (mainly women), lower class government functionaries (mainly men), rag pickers (men, children and some women), small business men and traders. Women and children, the focus of our study, worked mainly as domestic workers (women in other households and children in their own households) and rag-pickers and rubbish sorters. There were also ‘outsiders’, mainly shop keepers who came daily from the surrounding residential neighbourhood to the *basti*. They made profits selling large quantities of small items ('toast', phen, small packets of shampoo, washing powder, sweets, salty snacks, slush ice packets, small packets and bottles of cold drink, small pouches of tobacco) as well as more substantial quantities of basic food

items such as wheat flour, lentils, rice, sugar. According to one shop owner, there were a total of 52 shops like his in the *basti*.

In terms of the prevalence of children's illnesses in the *basti*, forty three of our household questionnaires indicated that the most self-reported cases of illness in the 4 weeks prior to the survey were to do with pneumonia, diarrhoea, fevers, cough, colds and vomiting. In the second order of occurrences were tuberculosis, skin rashes, itches, typhoid, shortness of breath, malaria and chickenpox. Single occurrences of jaundice, liver condition, worms, gas, body pain and broken limbs through an accident were also reported. This pattern of illness fits in with other anthropological studies of children's illnesses in developing countries. Nichter and Nichter for instance show that diarrhoea and acute respiratory infections (ARI) are among the chief causes of mortality and morbidity among infants and children in developing countries (1996). Diarrhoea, respiratory and skin infections are also everyday occurrences which frame the lives of children and adults in the *basti* as we see in the accounts below of the women and children living there.

2.2 Women's accounts

To get a sense of everyday life and concerns in the *basti* I will draw on the stories of 4 women: Urmila, Shajida, Kanchan and Asha. They are amongst a group of approximately one hundred women whose lives were documented as part of the wider study I was involved in. I have selected these women's accounts because they bring together some of the key issues in the relation between migration, gender, life-course and health in Rajasthan. The issues highlighted through these accounts are, for example, the different and constant ways in which migration occurs over the life-course of the poor, and the diverse ways in which mobility enables or disables the social, economic and health conditions for migrants and their children. The purposive selection of case studies is further supported by the findings of the latest report of the Urban Health Resource Centre which show that Muslims and Dalits constitute the overwhelming majority of the poorest 25 percent of urban residents in the major Indian cities (UHRC 2006).

Urmila, Shajida, Kanchan and Asha represent the different 'types' of women resident in the *basti*: those who have come to KN *basti* from a rural context at different stages in their lives (before, at and after marriage; Urmila and Shajida), those who have arrived elsewhere in the city first and then come on to settle in the *basti* (Kanchan), and those who have been long associated with city life and were born or grew up in the *basti*, classified as non-migrant in our study (Asha) The women were all between 30-35

years of age when I met them in 2004. Shajida belonged to the Sayyid Muslim community and Urmila, Kanchan and Asha were Harijan, low caste Hindus. Muslims and Harijans were the main ethnic groups in the *bast*i. Shajida was the poorest of the women and unemployed whereas Asha was well-off, with secure employment. All these women had experienced child mortality.

Urmila began her experience of migration early on in her life, as a child and long before marriage. This early migration has proved economically successful and socially empowering but the health of her children has remained poor. Despite poor health outcomes, Urmila regards her migration and life in the *basti* very positively. She has given birth and experienced child mortality in the village and the slum.

> I was born and lived in Todi Bhim village (3 hours away from KN basti by bus) until I was 10 years old. It was my father's village. Then I came to KN basti with my parents as they came to look for work. I lived here for 7 years. In between this time I got married when I was 15 years to a man in Ganganagar (eastern Rajasthan) but he died after a year so I came back to live with my parents. I got married again the following year and went with my husband to find work in Delhi. We lived there for 6 years and then went to his village in Sherpur (9 hours by train from Delhi) where we lived for two years with his family before coming to find work in KN basti. That was 8 years ago. Of my four sons only the last one, Rahul, now 8 years old, was born in KN basti. I had two abortions (safai) after his birth and had the 'operation' (tubectomy) during the second abortion. My other children were born in Sherpur, before coming to KN. My first son died when he was 5 years old. He used to get 'attacked' every fifteen days - his mouth would foam, his fist would close and his eyes would open…….. I prefer KN basti because my parents are here. My mother-in-law (sas) in the village did not allow me to go to the doctor or have any check-ups as she said there was not enough money. But in KN basti my children are very ill. My older boy has a rash (measles?). We showed him to doctor Tank (who has a private clinic just outside the basti) and we took him to hospital where he had 3 bottles of glucose. He then got diarrhoea. The younger one is having difficulty breathing. His ribs 'move'. He was kept in a 'machine' in Jaykay hospital (Jaykaylon mother and child public hospital) for a week. He had seen doctor Tank earlier who had advised us to take him there. The youngest one has large marks on his body that itch and this gets really bad in the winter or in the rains, as now. We have shown him to doctor Shekhawat and to the hospital but there is no difference. We have stopped doing anything about it……..I give my children a lot to eat but they are still so weak. KN is a better place because I can feed them well here. My youngest son got all his injections (teeke) once we came here. We have our own house. My husband contracts work out at a construction site at the transport office and earns Rs 5000/-. I work as a sweeper in around 15 houses and earn Rs 500/- and also get clothes and food in payment.

Urmila's account highlights a common paradox which emerged from the accounts of a number of women in the *basti*. Many of them viewed their migration to the *basti* in a positive light for the income, employment and raised standard of living it brought. Access to a better and greater range of food and clothes is seen as a direct result of her employment as a sweeper in wealthier households. At the same time, the *basti* was regarded as a dirty and polluted place, directly responsible for illness and disease. The restricted areas for defecation, open sewers, lack of clean drinking water, infestation by flies, rats and mosquitoes, cramped living, cooking and sleeping quarters and the exposure to industrial and chemical wastes, all made the *basti* a risky place to live in. The *basti* was also a major rubbish sorting depot (outsiders called it the *kachra* or rubbish *basti*) which made it all the more hazardous, especially for young children.

Urmila's account also importantly highlights two interrelated issues connected with her move to the *basti*. These are the autonomy which she experiences away from the control of her mother-in-law in the village, and related to this, the greater access she has to doctors and hospitals. But Urmila's ability to access the services of medical professionals is also based on her increased economic standing and earnings. Poorer migrants may not be able to avail of healthcare facilities because they do not have the resources to do so, as Shajida explains and Kanchen further emphasises below.

Shajida's migration begins at marriage and being Muslim she experiences more than one marriage-related migration. She views the move to the *basti* in negative terms: there has been no economic betterment nor have her children born here survived.

> I was first married at 19 years to a man who lived in Madhopur (small town approx. 3.5 hours drive away from Jaipur city). Madhopur is about 2 hours away from the village where I was born. I stayed for 7 years with my first husband and had four sons by him there. Then he left me and I had a divorce and returned to the village leaving the children with him. Then after a year my family married me off to my father's grandmother's son's son. This was when I came to KN *basti*. I had two daughters by my second husband here. I had my 'operation' (tubectomy) 5 years ago after my youngest girl Gulabsha was born. My sons were born in the government hospital in Madhopur but my daughters were born here in the *basti* itself: at the *anganwadi* childcare centre. My second son died, he 'dried up' when he was four months old, back in Madhopur. The *basti* is worse than the village, it is much dirtier here. Also you may have the doctors but you can't afford the medicines. So what is the use? Gulabsha is very ill all the time. Her whole body is swollen as you see, especially her stomach. The doctor says her liver is big. I have taken her to JayKay hospital (Jay kaylon mother and child government hospital) and to doctor Shekhawat (private

> doctor near the slum) but to no avail. I can't afford to keep giving her medicines. I don't work and my husband runs a glass crushing mill (I don't know how much he earns). His sons from his previous marriage live with us. The older boy sorts rubbish and brings in Rs. 50-60/- per day. The younger boy repairs bicycles and gets Rs. 20/- per day.

Kanchan is more of an urban migrant, compared to Urmila and Shajida, although like them was born in a village and migrated at marriage to another *basti* in Jaipur city. She views the *basti* positively in terms of the health of her children, although when it comes to birthing, she has consistently returned to the village.

> I was born in Soda village near Diggi about 3 hours away from Jaipur by bus. I got married when I was 14 years and left my village to join my husband in Amirpur village. We stayed there for 7 years before we came to Jaipur in search of employment. We first rented a room in the GG *basti* in the northwest part of the city, where my grandparents had migrated to. After 2-3 years we moved to KN *basti* where we were able to have our own place for Rs 2,200/-. I had 5 children before I came to Jaipur and one child, a son, now 10 years old, was born here. I had the 'operation' (sterilisation) about 8 years back. Only 3 of my children are still alive. After my oldest boy was born (he is now 18 years), two boys and a girl after him died: they became sick, 'dried up' and died. All my births took place at home. The first four were in Amirpur where a local midwife helped birth them. For the fourth child we called a 'nurse' (employee of local clinic or hospital) to assist because the previous two had died when attended by the midwife. But the nurse too could not do anything to save the child. Then for the fifth child I went back to my parents' village. Here we again called a 'nurse'. This time the child, my daughter, survived. I did not breastfeed her for 15 days as I felt my children died because of my milk but then my mother scolded me and I began to breastfeed her. The *basti* is a much better place than the village. Here there is employment and I can feed the children. My husband works as a daily wage labourer and I work as a sweeper in about 30 houses. My oldest son works in a factory from 8am till 8pm and brings back Rs 1,800 per month. I bring back some money but also get a lot of cooked food. I am back by lunch time and love watching TV after that. The children are not so ill either. The doctors are good. I first go to doctor Tank and then to doctor Shekhawat if I need to.

Both Shajida and Kanchan are 'migrants' but Kanchan has lived longer in the city and has more family connections in the city than Shajida. They have migrated for similar reasons of securing better employment, and the health of their immediate family was not a reason for movement. Marriage migration was evident in both cases and both women have given birth to their children 'at home', either in the village or in the *basti*. Kanchan had a nurse deliver her child in the village whereas Shajida had a local Muslim midwife from the inner city deliver her child in the slum. They have both experienced the

death of their children. Kanchan and Shajida, however, have contrasting views about the health advantages of their move to KN *basti.* For Shajida, the *basti* is a dirty place and connected with the deteriorating health of her daughter Gulabsha (Gulabsha died in 2005, six months after we met) and her inability to access medicines despite the availability of competent doctors. For Kanchan, like for Urmila above, the *basti* provides opportunities for better food and healthcare for her children. The contrasting views in relation to health were linked to the fact that, as a Muslim woman, Shajida is unable to work and earn a living compared to Kanchan. Kanchan's ability to earn and also have access to cooked food enables her to feel more empowered compared to her position in the village.

Asha grew up in Jaipur (although she was born in a village) and is classified as 'non-migrant' in our study. She regards herself as someone who belongs to the *basti*. She is the most self assured woman I met and is economically well off. She chews *zarda* (tobacco mixture) when we talk. Asha has a number of relatives in KN but also in other *basti* in the city. She has significant household support from her teenage daughter. She has given birth to all her children in the *basti*, and also experienced child mortality.

> I have lived in KN basti for over 20 years now. I was born in Bassi village (over 2 hours away by bus) and stayed for the first year with my maternal grandmother. I then joined my mother who was living with her first husband in the basti in Chandpol in Jaipur city. After 5 years or so we moved to Hasanpura town, just 10 minutes outside Jaipur, when my mother was with her second husband. I must have stayed there for only 6 months when I moved back to stay with my grandmother's brother who lived in KN basti. I married my husband in KN basti and have had all my children here. I sweep and clean the gutters for the government offices and earn Rs. 200/ per month. My husband earns around 1500/- per month from wage labour. I have given birth to 8 children in all but three, all boys, died. They died between 6-8 months after they were born. The first two 'dried up' and the third had a very big swelling in his leg from which he died. Golu would have been 10 years and Pappu and Lalla would have been between 6-9 years had they lived. Sunil, my youngest boy is 2 years old now. I had the 'operation' after he was born. Life is better now. My husband used to drink a lot and didn't care much for the house or us. Now my daughter Puja is jawaan (has come of age) and he has become sensible. The children are often ill with a fever, especially Sunil who constantly has boils and skin infections. I always show my children to doctor Tank who charges us Rs 10/- for medicines. None of my children have received any vaccinations. My two youngest have only had polio drops.

Asha has a lot of family living in the basti. They also have more space than others, occupying at least two 1-2 room tenements. One of these is near the brick boundary wall of the *basti*, where it borders the

main road. Here her daughter Puja (15 years old) cooks the food, makes tea for the guests and washes the clothes. Asha tells me that because she is out to work she can't do any housework. When I first meet Puja she is kneading around 1 kilo of wheat flour to make *roti* (unleavened bread) and looking after Sunil at the same time. She sits next to a gas stove cooker on the floor. The room has one new ar*khat* (bed) placed upright near the wall with clothes hanging on it. Next to it is a small wooden bench and a wooden stool. A clock hangs on the wall but it shows the wrong time. There is one shelf which runs around the wall and has some aluminium plates, spoons and glasses and also some kitchen masala. There is one aluminium storage box on which is placed a broken mirror, comb and some toiletries. This is certainly among the better off houses.

2.3 Children's accounts

In conclusion to this section, I would like to turn briefly to the perceptions of slightly older children, of the expectations placed upon them, and their well-being in the *basti* as it is connected to, as well as distinct from, that of their parents' experiences. Puja (15 years), Gaurav (10 years), and Phoolbano (12 years) were three of the children I met who spoke in detail about their life, work and aspirations. I begin with the story of Puja, who is Asha's daughter, as we saw above.

Asha's work, which takes her away from the house, has major implications for her older daughter. Puja tells me she wants to go to school (to become 'something') but cannot do so because she has to do the housework and look after the younger children. She gets up at 7am and makes tea for everyone. She then does the sweeping and washes everyone's clothes. She feeds Sona (5 years) during her break period when she comes home from the voluntary school in the *basti* and also makes the *roti* for the household. She gets a bit of time free in the afternoon when she loves to watch TV. She then has to make the evening meal which takes her around two hours between 4-6pm. I ask her what happens if she falls sick. She gives me an example: approximately 2 months back she suffered from loose motions and passed blood in her stool. Her father got her one pill from a doctor and that was enough to make her better. Puja said her father often got her medicines when she was sick and cooked her *khichdi* (rice and lentils boiled), and also brought her some fruit (like a banana or an apple). He is good as he does not beat her or the other children. But she normally continues to work when she is ill as well. It is her youngest brother who is constantly sick with *phunsi* (boils) on his legs and arms. They may get better but then reappear. They have spent Rs. 3-400/- on his treatment but there is no change. I see Sunil defecating in front of the room. He is roaming around without any clothes on.

There are a lot of flies all around us while Puja is cooking. She says she keeps wiping (poncha) the floor with a wet cloth but they keep returning. She puts on the electric fan to get rid of them temporarily. The flies here bring in dirt from the other side of the boundary wall, on the road, where the little children are sent every morning to defecate. As we are talking a rat emerges from under the cooker. Puja shows me the gaping hole where it comes from and says the floor has rat tunnels underneath. She says they don't kill them as her mother says she does not want to use poison in case it gets in the food, or the children eat the sand. Others in the basti say that they prefer to capture the rats and throw them in the nallah rather than kill them because rats are hanuman ki sawari (the chariots of the monkey god Hanuman) and therefore sacred.

Gaurav is around ten years old. His father is Puja's *chacha* (father's brother). His family are poorer than Puja's family and neither of his parents has any regular wage. Gaurav's mother is also a 'non-migrant' but her life circumstances have made her as socially vulnerable and poor as Shajida who has few relatives in the city. Both their children collect rubbish and face the same risks. He goes rag-picking every morning. Gaurav says he collects used plastic milk bags (the rate for these is Rs 8/- per kilo) or used cardboard sweetmeat boxes (the rate is Rs.2/- per kilo). After he collects them from the rubbish heaps near the *nallah* (big open drain) he sorts them and then takes them to the Muslim collection point (Muslim families run this business in KN *basti*). He says he got hurt once while rag-picking, a lot of blood flowed and they did an x-ray. Gaurav's mother told me that he fell down the *nallah* (steep open drain) one day and hurt his foot on a broken tomato ketchup bottle. There was a lot of blood. He had a major operation on which they spent over Rs. 3000/-. Gaurav says he is generally never ill but does suffer from stomach pains. The pains come whenever he eats a bit of *roti* but go away the moment he drinks some water.

Phoolbano is around 12 years old and is one of four siblings. There were seven all together she tells me but 3 have died. (Her mother, Guddi, confirms this by saying that the twins born to her died at birth and another girl was stillborn, probably because her husband had kicked her in the stomach when she was pregnant.) Phoolbano's father had subsequently also died. He used to be very ill and drank and smoked a lot. He had three operations and they had to spend over Rs. 3000/- on him. Her mother did not work and always complained of headaches. Her mother had no relatives in the *basti* and had also cut off all communication with her Hindu family in Gujarat when she got married to Phoolbano's father who was a Muslim. They survived through the earnings made by Phoolbano's elder brother, who plied an auto-rickshaw. They ate from whatever was left over after he paid back the hire charges of Rs.100/- daily. Phoolbano said they did not eat rice, curd or fruit ever. They would mostly eat *roti* with crushed red or

green chillies. In the morning she drank a small cup of tea which had some milk in it. She says in general she has very little blood in her body. She had *peeliya* (yellow illness, jaundice) till a fortnight ago. She was cured by the baba near the bus stand who swept and 'blew' on her (*jhad-phoonk*). On his advice she drank some skimmed buttermilk and also wore a green thread and amulet. If she could afford it she would like to study and become a doctor, to be able to help people who, like her father, become very sick.

The children's accounts highlight the difficult living conditions that older children face whose health has not been accounted for in the statistics on child mortality (1-5 years). Puja's illness was treated by a single tablet administered by her father while Phoolbano's jaundice was seen to by a local faith healer. Gaurav's case highlighted the daily risks of physical injury children face in the *basti* but also the expense that his parents incurred to make him better. These are children who have survived through the difficult first five years of their life. In terms of the future, if he continues to reside in the *basti* Gaurav will probably carry on in the rubbish trade while Puja and Phoolbano will be married into another village or *basti* to bear offspring and possibly go on to earn money through domestic work. As is the case with the movement of women to the urban context, the monetary contribution of children (especially sons) to poor households increases with migration. This value is further reflected in the differential health-related expenditure on girls as opposed to boys.

3. Discussion

The increasing levels of migration taking place within India (Indian cities over 1 million now have nearly one-third of their population made up of migrants; Stephenson et.al. 2003) point toward the rising numbers of people who face a dislocation in their living conditions and the health consequences as a result of this.

Recent measures taken by the state government of Rajasthan acknowledge the need to focus on the urban poor. For instance, the state population policy (1999) aims to provide 1 Reproductive and Child Health centre for every 20,000 people, also to be set up in slum areas (UHRC 2006). Several schemes have been set up such as the Medicare Relief Card system (1999) to provide free medical services to the urban poor at the state hospital, and more recently the Janani Surakhsha Yojana (JSY; 2005) has been set up to ensure antenatal, delivery and postpartum care to poor pregnant mothers who are given Rs 600/- towards this end at the time of their delivery. There are also more general schemes for the urban poor which address their housing and sanitation and employment / food security needs, such as

the Jawarharlal Nehru National Urban Renewal Mission (JNNURM; 2005) which is funding projects on improving water supply, sewage and waste management, provision of toilets, lighting, child care centres in 60 cities in the country, including Jaipur. There are also urban self-employment and wage employment programmes which have been initiated. Some of these programmes will no doubt provide critical relief to the urban poor. They may still not be able to reach the most vulnerable group, including a number of migrant families. In order to understand the specific characteristics of the urban migrants, we need first to learn from their experiences.

The accounts of low caste Hindu and Muslim women and children in KN *basti* provide an understanding of how birth, health and migration are perceived by the migrants themselves and how these views and experiences are both connected and disconnected from those who are longer term residents in the same place. Among the practices that cut across the rural and urban contexts is, firstly, the tendency to give birth at 'home', whether that is in the village or in the *basti*. Second is the experience of child mortality and a shared language and illness aetiology (which emerge, for example, in the explanation of child death given by migrant as well as non-migrant women as a result of 'drying up').

In the ethnographic accounts presented above, children's health and well-being emerge as the result of a complex combination of factors, which include mother's work, independent income, nutrition, father and his relatives support to their mother, willingness and ability to access emergency reproductive care, awareness of health risk and implications of local aetiology, access to good curative services for the children and a safe social and physical environment, including clean drinking water, a proper drainage system and rodent and pest free conditions of living.

Notions of health were, however, submerged within wider discourses of well-being, such as to do with ownership and employment. Migration was *indirectly* connected to health in that it was seen as an important means of procuring better livelihoods, income, food and residence. What mattered most to *basti* residents was whether their house was *khud ka* (their own) or *kiraya ka* (rented) and whether they had enough to eat and feed their children. In the words of one resident, 'how can we be concerned about matters like health (*swasthya*) when we don't even have enough to eat'? The connection between income and food was particularly stark for those households that were dependent on daily wage earnings. Here family members ate on a more ad hoc basis, sometimes postponing meals until the money had come in to buy food. When families move out of rural contexts, they also lose the access their children have to mid-day meals provided at rural schools, and in this sense become worse off as a result of their move.

Nevertheless, a number of migrants saw the *basti* as a place where their children could have access to a greater amount and range of especially cooked and 'junk' food. (Although parents regarded the *basti* as a place where children were distracted by 'junk food' such as hard sweets, crushed ice with flavouring, this was not seen as a major problem by residents). Most children of the women in our qualitative survey of daily and weekly intake of foods, drank half a cup of tea in the mornings (made from milk used for tea for the whole family) and either had a 'toast' (rusk) or *roti*. A further main meal of a *roti* with a 'small portion' (*aadha katori*) of lentils or spicy vegetable was usually all that they had in the day. Very few children drank milk, or consumed curd, eggs or fresh fruit. Goat meat or chicken was occasionally eaten but the portions were small as the dish was shared amongst a number of family members. Even though children did not have a nutritious diet by biomedical standards, access to food was seen as an advantage of living in the *basti*. NFHS-2 data has pointed to the high levels of maternal and childhood anaemia and its close relation to maternal and infant mortality (see Bose for the reliability of NFHS-3 findings on anaemia; 2006). More than 70 percent of children between 6-35 months in the report are shown to have some form of anaemia (classified as mild-20%, moderate-53% and severe-10%; 2001: 174/75).

The favourable position of the *basti* in relation to the feeding of children was a connection particularly made by the women who worked as domestic helpers and earned in kind (cooked food such as rice and curry; clothes) as well as cash. Women who did not have independent earnings and access to cooked food were also the ones who felt their children were worse off in the *basti* as compared to the village, where women had fewer opportunities to work and earn food. This again supports NFHS-2 data which state that the children of mothers who are self-employed are less likely to have moderate or severe levels of anaemia. This was particularly the case with Muslim women who were not allowed to work outside the house. There was a further connection between women's employment and children's nutrition. In terms of breastfeeding, there was a tendency for women who were employed to give this up much earlier and switch to other kinds of milk (goat, cow, tinned), compared to women who did not work. Women who worked also shifted much of the childcare and household chores onto their older children, especially daughters.

The access to food gained by their move to the *basti* was offset in local perceptions by the view of the *basti* as a dirty, rodent-and-mosquito infested environment. The pollution included the more hazardous chemical wastes that made up the environment which the children lived and worked in. The lack of proper drainage and toilet facilities meant that there was a high incidence of diarrhoea. Diarrhoea (*dusth* or *tutti lagna*) was, however, not regarded as an illness and was seen to be a result simply of what one

ate or drank (*khana-peena*). It was also not regarded as something for which medicines were sought or a doctor consulted. The insignificance attributed to diarrhoea and related underreporting is very likely to contribute significantly to child morbidity and death in the *basti*. The effects of dehydration or *sookhna,* a common reason given by parents for the unexplained death of their infants, were not linked to diarrhoea in local perceptions. The inability to distinguish between diarrhoea and dysentery, for example, is a common cause of infant death elsewhere in South Asia as Nichter and Nichter (1996) point out. While it is easy to lay the blame of child deaths in such cases as being due to parental ignorance or neglect (Finerman, 1995) it is often that health workers working in these contexts are themselves unaware of the differences and the dangers of blood in the stool indicated in the latter. Recognising the difference between diarrhoea and dysentery is important in determining the nature of the cure as being an oral rehydration packet or an antibiotic. The NFHS-2 report also does not distinguish between diarrhoea and dysentery. In fact it positively discourages the use of drugs to treat childhood diarrhoea (2001; 146).

Fevers, on the other hand, were regarded by *basti* residents as signalling serious illness and were treated with greater concern. I was told by the mothers I met, that a fever was a serious matter and that doctors have to be consulted when a child had a fever. Both migrant and longer term residents sought out private doctors rather than public ones to treat their children's fevers as they tended to be near the slum. Curative services for children were keenly sought by migrants and non-migrants alike and were mainly from private doctors who were established in the locality of the *basti*, such as doctors Tank and Shekhawat mentioned in nearly all the accounts of *basti* residents. Migrants sought a greater range of private services, often going back to the village and previous places of residence to access local healers. The long term residents were more likely to make use of hospital services in the city, which was a function of the greater social capital they had in the form of relatives and friends.

Access to medical services was seen as better in the *basti* than outside the city, but the question of cost and finances to cover especially chronic illness, made them inaccessible to a number of residents, often recent migrants. A number of longer term residents also had a low uptake of services because they were poor. This points to the levelling factor of socio-economic variables on the effects of migration. A similar observation has been made by Stephenson, Mathews and Macdonald (2003) in their study on the relationship between under-two child mortality and migration using the 1991/92 NFHS data for a group of approximately 90,000 women aged 13-49 years in all states in India. They suggest that when controlling for socioeconomic factors and health utilisation variables, the effects of rural to urban migration on the survival rate of children disappear, meaning that migration makes no difference.
At another level, also tied in to economic circumstances but equally connected to ideas of birthing as a

natural bodily function, was the practice among migrant and non migrant residents of giving birth at home. This finding supports the UHRC data which suggests that 79% of the urban poor deliver their children at home (UHRC 2006).

Home could be in the village or the *basti* and with the affinal or natal family. In general, birth was not regarded as requiring medical intervention by either migrant or long term residents. The number of women who gave birth in hospitals was most frequently restricted to those who had relatives working there as sweepers or cleaners, and usually these were longer term residents. Otherwise, the hospital was a place identified with 'problems' and birth was not considered a 'problem' in the sense of an illness or ailment. The uptake of antenatal services per se was fairly non-existent, except by those who experienced problems during their pregnancies. Local midwives attended births in both the village and the slum, as did private service 'nurses'. Most of the women I met in the *bast*i had undergone a tubectomy and in fact being in the *basti* made access to this particular reproductive technology much easier (as it is a common service offered to poorer women at public hospitals in the interests of the state's population management strategies.)

The child immunisation services were less easy to administer when births took place at home. The uptake of whatever immunisation was provided by health visitors to the slum was poor and patchy, largely because the need for preventive care was not considered important. UHRC figures suggest that only 7.4% of urban poor children between 12-23 months are fully immunised. Most residents feared injections and associated it with powerful substances to be avoided. I was told that one only sought injections when there was a 'problem'. This explained another apparent inconsistency to me, that injections were intensively sought after when children were ill and thus for curative purposes, but not to prevent illness as in the case of immunisation. The only immunisations that are successful are those against polio. The polio campaigns are successful in large part because the vaccine is easily administered in the form of sugar drops. Childbirth per se is therefore not considered a time of risk in migrant and non-migrant perceptions alike and nor is the notion of immunisation well developed, as the accounts in the previous section also suggest.

4. Conclusion and policy considerations

Drawing on the experiential accounts of women and children in a *basti* in Jaipur city, and wider public health-related documentation on birth and mortality in Rajasthan, the chapter has reflected on a number of issues. Firstly, the chapter considered what migration means and how it is experienced in the specific

context of a resource-poor state such as Rajasthan, which has among the highest rates of infant and child mortality in the country. It described how population movement among poor semi-skilled migrants in search of employment is 'chronic' and non-linear, involving a range of different kinds of movement which criss-cross over rural and urban boundaries, between urban settings and occurs at specific moments in the life-course of women. It showed how health outcomes are indirectly connected to movement, and health is perceived primarily in social and economic rather than medical terms. This is further borne out by the fact that while residence in the *basti* means one can be closer to a range of health facilities, poor economic circumstances restrict access to health services for residents. Poor economic circumstances also suggest a higher level of child mortality and morbidity and are more closely associated with migrant than non-migrant families.

There is an ambivalence in the local perceptions of migrants with regard to children's health: where, on the one hand, migration leads to children's improved access to food, but on the other hand, subjects children to the vagaries of a polluted environment and related health risks. The paper also suggested that migration is gender-related and has a specific impact on women in terms of how they experience birth and how their changed domestic roles and relationships impact on the survival chances of their children, as well as their own sense of autonomy and agency. It discussed how the culture of birthing at home is shared across migrant and non-migrant families, with access to emergency care being the main determinant which sets the *basti* apart from more rural contexts. Social networks, known contacts such as kinspeople, in institutional settings as clinics and hospitals work in favour of non-migrants over migrants.

The study raises important policy implications for planners concerned with poverty, insecurity and social cohesion. Some critical measures that can be taken to address the detrimental health experiences of poor migrant women and children described in this paper are as follows:

- Urban slums lack basic health infrastructure. It is urgent that primary health services (available in rural areas) are provided equally for those living in deprived urban settlements. It is not enough to provide these services as adjunct to the main government hospitals. This finding supports the recommendation of the recent UHRC report (2006).
- It is vital that the number and quality of provision of Anganwadi centres for pregnant women, neonates and infants includes provision of meals for young children, but also health referral services for migrant mothers' antenatal, birthing and postpartum care. The anganwadi needs to provide viable social support and act as a community support centre for which separate infrastructure needs to be provided (for example, an independent set of rooms).

- It is important to develop tracking and communication strategies to ensure that migrant mothers in particular have access to emergency services. Referral routes need to be set in place, which work across district and towns. As birthing most often takes place 'at home' (a practice which may vary between the village or the city across an individual woman's reproductive life span) for economic reasons and because it is a non-medicalised event in local perceptions, it is important that routes to emergency care are clear and readily available (for the significance of referral services see Hulton, Mathews and Stone 1999; Unnithan-Kumar 2004).
- Health-workers need to target migrant families who have experienced child loss for specific attention and intervention. One of the major conclusions to emerge from Dasgupta's study on the clustering of child deaths, for example, has been that targeting women who have suffered their first child loss would have a significant impact on lowering child mortality (1997: 201).
- Equally critical is the provision of prompt, diagnostic and referral services for diarrhoea, dysentery and respiratory conditions in children. A recommendation relating to childhood morbidities (illnesses which potentially can cause death) and especially the high incidence of diarrhoeal cases in the *basti* would be for better information on the symptoms and treatment to be made available to migrant parents, especially in terms of differentiating less from more severe cases and dysentery. Moreover, as Nichter and Nichter recommend for elsewhere in South Asia (1996), it is important for health-workers and anganwadi personnel to be made aware of the different pathogens and treatments involved in cases of diarrhoea and dysentery and the need for urgent action.
- Finally, in order to generate positive health outcomes of especially poor migrants, it is vital that government and NGO health personnel are able to recognise the early signs of economic distress faced by migrant households in particular. This means developing specific schemes within the category of the urban poor such that the specific social and economic vulnerability of migrant households is recognised.

In conclusion, the paper has shown, above all, that migrants, especially women and their children are vulnerable due to two main factors: first, their constant movement which includes smaller cycles of movement in relation to birth within wider cycles of movement in relation to employment. Second, as migrants, they are less likely than longer term residents to be proactive on health issues which tend to be submerged within more immediate economic concerns of securing employment and economic betterment in a context where there is also relatively little support from kin.

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References

Brockerhoff M. (1994): 'The Impact of Rural-Urban Migration on Child Survival', *Health Transition Review*, 4(2): 127-149.

Brockerhoff M. (1995a): 'Child Survival in Big Cities: The Disadvantages of Migrants', *Social Science and Medicine*, 40(10): 1371-1383.

Basu A. M. (1990): 'Cultural Influences on Health Care Use: Two Regional Groups in India', *Studies in Family Planning*, 21(5): 275-286.

Bose, Ashish, (2006): 'Falling Fertility and Rising Anaemia', *Economic and Political Weekly of India,* Mumbai: Hitkari, September issue: 3923-3926.

Dasgupta, M. (1997): 'Socio-Economic Status and Clustering of Child Deaths in Rural Punjab', *Population Studies*, Vol. 51, No.2, July: 191-202.

Finerman, R. (1995): "'Parental incompetence" and "selective neglect": Blaming the victim in child survival', *Social Science and Medicine,* 40:1, 5-13.

Hulton, L., Mathews, Z., Stone, R. (1999): *A Framework for the Evaluation of the Quality of Care in Maternity Services*, Southampton University.

International Institute for Population Sciences (IIPS) and ORC Macro (2001): *National Family Health Survey (NFHS-2), India, 1998-99: Rajasthan*, Mumbai: IIPS.

Migration DRC (2005a): 'Migration and the Millennium Development Goals for Health', DRC Policy Briefing Series No.1.

Migration DRC (2005b): "Workshop Report 'Migration, Urban Poverty and Health'", Sussex, 10 May 2005.

Misra, R., Chatterjee, R., Rao, S. (2004): *Indian Health Report*, Delhi: Oxford University Press.

Nichter, M., and Nichter, M. (1996a): 'Health Social science research on the study of diarrhoeal disease: a focus on dysentery', Chapter 4, in *Anthropology and International Health,* London: Gordon and Breach.

Nichter, M., and Nichter, M. (1996b): 'Social science lessons from diarrhoea research and their application to ARI', Chapter 5, in *Anthropology and International Health,* London: Gordon and Breach.

Scheper-Hughes N. (1985): 'Culture, Scarcity and Maternal Thinking: Maternal detachment and Infant Survival in a Brazilian Shantytown', *Ethos*, 13: 291-317.

Scheper-Hughes N. (1987), 'Culture, Scarcity and Maternal Thinking', Reprinted in *Child Survival:* 187-210.

Sinha, A. (2005): *India Democracy and Well-being: An enquiry into the persistence of poverty in a dynamic democracy*, N. Delhi: Rupa.

Stephenson, R., Matthews, Z., and McDonald, J.W. (2003): 'The impact of rural-urban migration on under-two mortality in India', *Journal of Biosocial Science*, 35: 15-31.

Urban Health Resource Centre. (2006): *State of Urban Health in Rajasthan*, Report commissioned by the Ministry of Health and Family Welfare, Government of India.

Unnithan-Kumar M. (2004): 'Spirits of the Womb: Migration, Reproductive Choice and Healing in Rajasthan', In F.Osella and K.Gardner eds., *Migration, Modernity and Social Transformation in South Asia,* Delhi: Sage.

Unnithan-Kumar, M. (2004): 'Reproductive health and medical pluralism in Rajasthan: forward looking strategies', In. S.Singh and V.Joshi eds., *Social Institutions and Social Change*, Jaipur: Rawat.